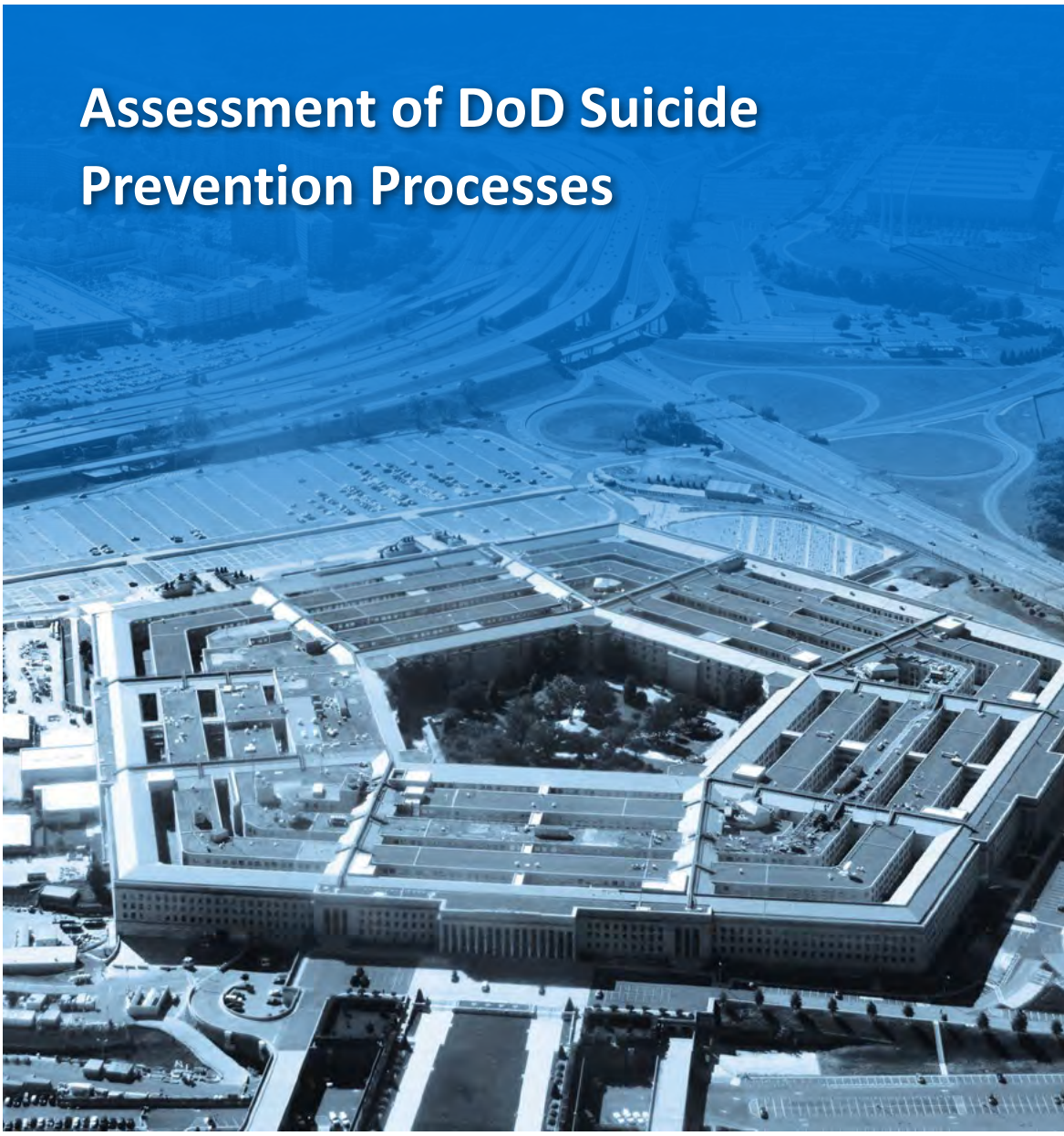
Report No. DODIG-2015-182

INSPECTOR GENERAL

U.S. Department of Defense

SEPTEMBER 30, 2015

Assessment of DoD Suicide Prevention Processes



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Results in Brief

Assessment of DoD Suicide Prevention Processes

September 30, 2015

Objective

The objectives of this project were to: 1) evaluate DoD processes used to develop suicide prevention policy and 2) determine what process changes are required to improve suicide prevention and intervention policies and programs, including, but not limited to, resilience, mental health treatment, substance abuse, and postvention[1] in the military.

Observations

The observations included in this report were:

- DoD lacked a clearly defined governance structure and alignment of responsibilities for the Defense Suicide Prevention Program. The lack of synchronization between the DoD Directive[2] and DoD committees chartered by the Under Secretary of Defense for Personnel and Readiness and Defense Suicide Prevention Office resulted in less than effective DoD strategic oversight of its suicide prevention program and impeded program implementation.
- The Defense Suicide Prevention Office lacked clear processes for planning, directing, guiding, and resourcing to effectively develop and integrate

[1] Postvention is a "response to and care for individuals affected in the aftermath of a suicide attempt or sudden death." U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.* Washington, DC: HHS, September 2012.

[2] DoD Directive 6490.14, "Defense Suicide Prevention Program," June 18, 2013.

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Observations (cont'd)

the Suicide Prevention Program within the DoD. In the absence of a fully developed suicide prevention strategic plan, DoD Instruction, and alignment of staff-to-mission priorities, there was no unified and coordinated effort to address suicide prevention across the DoD, and the Services continued to create their own Service-unique suicide prevention initiatives.

- The Defense Suicide Prevention Office did not consistently identify, share, or implement evidence-based suicide prevention best practices across the DoD. Subject matter experts were not used to prioritize and advise on implementation of evidence-based suicide prevention best practices. As a result the DoD did not standardize best practices across the department, and the Services did not take advantage of each others' knowledge and experiences.

Recommendations

We recommend the Under Secretary of Defense for Personnel and Readiness:

- Revise the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," to clearly define and integrate the leadership roles and responsibilities of the Assistant Secretary of Defense for Readiness and Force Management, Deputy Assistant Secretary of Defense for Readiness, Defense Human Resources Agency, and Defense Suicide Prevention Office regarding program strategic oversight, decision making, and action execution.
- Revise and synchronize the Suicide Prevention and Risk Reduction Committee and Suicide Prevention General Officer Steering Committee charters with the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," to ensure program governance structure and responsibilities are clearly defined and aligned.

Results in Brief

Assessment of DoD Suicide Prevention Processes

Recommendations (cont'd)

- Subsequently, upon revision of the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," (see Recommendation 1a.), develop and publish a comprehensive suicide prevention Department of Defense Instruction.
- Expedite publishing a directive-type memorandum that provides interim Department of Defense suicide prevention guidance.

We recommend the Defense Suicide Prevention Office:

- Develop, publish, monitor, and communicate a comprehensive suicide prevention strategic plan with updated vision, goals, and objectives, and include performance measures and timelines.
- Develop a plan that aligns budgetary and personnel resources to meet mission priorities.
- Develop a research strategy using subject matter expertise to report and analyze evidence-based suicide prevention recommendations for applicability to the Department of Defense.
- Provide an implementation strategy to adapt Department of Defense applicable evidence-based suicide prevention research findings into standard practices across the Department.

Management Comments and Our Response

We received comments from the Acting Under Secretary of Defense for Personnel and Readiness. Management agreed in whole or in part to the recommendations. We request additional comments as detailed in the Recommendations table on page iii. The full reproduction of the comments received is included in this report.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Under Secretary of Defense for Personnel and Readiness		1.a, 1.b, 2.a, 2.b
Defense Suicide Prevention Office	3.a	2.c, 2.d, 3.b

Please provide responses by October 30, 2015.


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INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

September 30, 2015

MEMORANDUM FOR UNDERSECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

SUBJECT: Assessment of DoD Suicide Prevention Processes (Report No. DODIG-2015-182)

We are providing this report for review and comment. The report provides an assessment of the processes DoD used to inform decision makers in the development of suicide prevention policy. We conducted this assessment from November 2014 to August 2015 in compliance with the "Quality Standards for Inspections and Evaluations," published in January 2012 by the Council of Inspectors General on Integrity and Efficiency.

DoD OIG Special Plans and Operations (SPO) formally announced a research phase (phase 1) on suicide prevention programs within the DoD and concluded that further DoD OIG assessment of the program was warranted. SPO published "Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment" (phase 2) on November 14, 2014, which addressed suicide data collection issues. This assessment is the third phase in a series of reports published by the DoD OIG that focus on the DoD Suicide Prevention Program.

We considered management comments in a draft of this report when preparing the final report. We request additional information as outlined in the Recommendations Table on page iii.

Please send a PDF file containing your comments to SPO@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We cannot accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We should receive your comments by October 30, 2015. Comments provided on the draft report must be marked and portion-marked, as appropriate, in accordance with DoD Manual 5200.01 and should conform to the requirements of DoD Instruction 7650.03. You should describe what actions you have taken or plan to take to accomplish the recommendations and include the completion dates of your actions.

We appreciate the courtesies extended to the staff. Please direct questions to [redacted].

Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations


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Contents

Contents (cont'd)

Noteworthy Progress

Defense Suicide Prevention Office

The Defense Suicide Prevention Office (DSPO) was established in November 2011. In May 2012, Secretary Panetta noted that the Under Secretary of Defense for Personnel and Readiness (USD [P&R]) established DSPO to serve as a focal point within DoD for suicide prevention policy, training, and programs. Since its establishment, DSPO made noteworthy progress on suicide prevention. Selected noteworthy progress included:

- DoD partnered with the Department of Veterans Affairs (VA) to—
  - Develop outreach efforts to promote the Military Crisis Line in collaboration with the VA, which is promoting the Veterans Crisis Line.
  - Create the Suicide Data Repository (SDR). The SDR, made formal through a charter, is intended to be a single repository to store all suicide-related events for service members and veterans. In addition, National Death Index Plus mortality data was purchased through Centers for Disease Control and Prevention to facilitate DoD and VA mortality studies. However, the program has not yet been made formal through policy and instructional guidance.
- The USD (P&R) coordinated with DSPO to—
  - Adopt the 13 goals and 60 objectives of the 2012 National Strategy for Suicide Prevention framework.
  - Standardize the suicide reporting methodology and suicide rate calculations within the Services and DoD.
  - Publish guidance for commanders and health care professionals in DoD on reducing access to lethal means through the voluntary storage of privately-owned firearms.

We acknowledge the ongoing efforts of DSPO to develop and implement effective suicide prevention initiatives.


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Introduction

DoD OIG Special Plans and Operations (SPO) formally announced a research phase (phase 1) on suicide prevention programs within the DoD and concluded that further DoD OIG assessment of the program was warranted. SPO published "Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment" (phase 2) on November 14, 2014, which addressed suicide data collection issues. Using information gleaned from this report and our own research and analysis, DoD OIG announced "Assessment of DoD Suicide Prevention Processes," (phase 3) to assess DoD-level processes used to develop suicide prevention policy. The DoD OIG will continue to assess the execution of DoD Suicide Prevention Program initiatives in future assessments. The DoD OIG phased approach is depicted in Appendix C.

Objective

The objectives of this project were to: 1) evaluate DoD processes used to develop suicide prevention policy and 2) determine what process changes are required to improve suicide prevention and intervention policies and programs, including, but not limited to, resilience, mental health treatment, substance abuse, and postvention in the military. The assessment focused on the actions by and the interactions between DSPO, members of the Suicide Prevention and Risk Reduction Committee (SPARRC), and members of the Suicide Prevention General Officer Steering Committee (SPGOSC).

Background

DoD Task Force on the Prevention of Suicide by Members of the Armed Forces

Responding to a rising suicide rate among members of the U.S. Armed Forces from 2001 to 2008 and the requirements of Section 733 of the Duncan Hunter National Defense Authorization Act for FY 2009, the Secretary of Defense established the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces on August 7, 2009 (hereafter, the Task Force).

The role of the Task Force was to examine, draw conclusions, and issue recommendations to improve DoD's suicide prevention initiatives. The Task Force was specifically tasked "to examine matters relating to prevention of suicide by members of the Armed Forces." In August 2010, the Task Force published,

"The Challenge and the Promise: Strengthening the Force, Preventing Suicides and Saving Lives," which included 76 recommendations to improve DoD's suicide prevention efforts. In September 2011, the USD (P&R) briefed Congress that 36 of those recommendations required new actions to be taken; 34 recommendations had actions planned, underway, or completed; and 6 recommendations did not merit any action. The recommendations related to organization and leadership; wellness enhancement and training; access to and delivery of quality care; and surveillance, investigations, and research. (See Appendix E for a list of the 36 recommendations.)

The Task Force's first recommendation was

> to build, staff and resource a Suicide Prevention Policy Division at the Office of the Secretary of Defense within the Under Secretary of Defense for Personnel and Readiness that would effectively develop, implement, integrate and evaluate suicide prevention policies, procedures and surveillance activities with respect to resilience, mental fitness, life skills, and suicide prevention.

The Task Force concluded that effective suicide prevention required supporting leaders at every level, providing service members the best available resources, and fostering a culture of total fitness of the force—Total Force Fitness. DoD advanced toward accomplishing these recommendations when the Department established DSPO in November 2011. In addition, DoD Directive 6490.14, "Defense Suicide Prevention Program," June 18, 2013, described the authority for strategic suicide prevention oversight and coordination from the Office of the Secretary of Defense (OSD), though the Services, to the unit level. Appendix D illustrates a historical perspective of DoD efforts directed toward suicide prevention from 2001 to the present.

Defense Suicide Prevention Office

As a result of the Task Force's findings on suicide prevention, DSPO closely aligned its mission to their recommendations. According to the Annual Report for FY 2013, DSPO's mission is

> provide DoD oversight for the strategic development, implementation, centralization, standardization, communication and evaluation of DoD's suicide and risk reduction programs, policies and surveillance activity to prevent suicide and enhance the mental health of Service members and their families.[3]

[3] Department of Defense, Defense Suicide Prevention Office, Annual Report for Fiscal Year 2013.

New Leadership

During the course of our fieldwork, the Defense Human Resources Activity elevated the Director, DSPO position to Senior Executive Service, and selected a new Director on February 9, 2015.

Subsequent to our fieldwork, the new Director, DSPO completed a 90-day informal comprehensive review and initiated program improvements to DSPO. In addition, the new Director, contracted with the Institute for Defense Analysis[4] to conduct a full scale program review of the Defense Suicide Prevention Program and to provide recommendations for future program alignment. Although the team did not observe or review the new DSPO director's initiatives, we acknowledge DSPO's ongoing efforts to improve the program.

The new DSPO Director—

- completed a 90-day review,
- initiated program improvements, and
- contracted out for a full scale program review.

Active and Reserve Military Suicide Rates from 2014

As of January 2015, suicide rates remained high, although the data reflected a slight decrease in the overall suicide rates for both the Active and Reserve Components from 2012 to 2014. However, the Active Component experienced a slight increase in 2014, as did the Reserve and National Guard Components in 2013. Table 1 from the "Department of Defense Quarterly Suicide Report Calendar Year 2014, Fourth Quarter," details the suicide counts by Component and Service.

[4] Institute for Defense Analysis is a not-for-profit corporation that operates three Federally Funded Research and Development Centers. The Systems and Analysis Center assists the Office of the Secretary of Defense, the Joint Staff, the Combatant Commands, and Defense Agencies in addressing important national security issues, focusing particularly on those requiring scientific and technical expertise.

Table 1. Suicides by Component and Service

DoD Component and Service	2012	2013			2014				
	Total Suicide Counts	Q3 Suicide Counts	Q4 Suicide Counts	Total Suicide Counts	Q1 Suicide Counts	Q2 Suicide Counts	Q3 Suicide Counts	Q4 Suicide Counts	Total Suicide Counts
Active Component	**320**	**71**	**60**	**254**	**73**	**70**	**56**	**69**	**268**
Air Force	50	15	12	48	19	11	12	17	59
Army	165	33	29	120	27	31	31	33	122
Marine Corps	48	14	9	45	11	9	6	8	34
Navy	58	9	10	41	16	19	7	11	53
Reserve Component	**192**	**53**	**57**	**220**	**46**	**34**	**47**	**39**	**166**
Reserve	**72**	**24**	**21**	**86**	**24**	**14**	**20**	**21**	**79**
Air Force Reserve	3	5	4	11	2	1	3	4	10
Army Reserve	50	16	12	59	13	4	15	10	42
Marine Corps Reserve	11	2	4	11	4	5	1	2	12
Navy Reserve	8	1	1	5	5	4	1	5	15
National Guard	**130**	**29**	**36**	**134**	**22**	**20**	**27**	**18**	**87**
Air National Guard	20	6	4	14	6	2	4	2	14
Army National Guard	110	23	32	120	16	18	23	16	73

Note: Suicide counts are current as of January 31, 2015.

Source: Information taken from the Defense Suicide Prevention Office, "Department of Defense Quarterly Suicide Report Calendar Year 2014, Fourth Quarter."

Observation 1

Lack of Clearly Defined Governance Structure and Responsibility

DoD lacked a clearly defined governance structure and alignment of responsibilities for the Defense Suicide Prevention Program.

This occurred because the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," and the charters for the SPGOSC and the SPARRC had not been synchronized.

As a result, DoD provided less than effective strategic oversight of its suicide prevention program and program implementation was impeded.

Discussion

DSPO's organizational structure was announced in 2012 as an entity housed under USD (P&R). This was followed by the publication of the DoD Directive 6490.14, "Defense Suicide Prevention Program," June 18, 2013 (hereafter, the Directive), which established policy, assigned responsibilities for implementation of the Defense Suicide Prevention Program, and established the SPGOSC and the SPARRC. After the Directive was published, the DoD SPGOSC Charter (October 22, 2013) and the DoD SPARRC Charter (November 4, 2013) codified their committees. The USD (P&R) organizational structure was updated in 2015.

These documents listed above were internally inconsistent with each other, were not synchronized, and contradicted each other on matters of strategic and policy oversight, leadership direction and control, and resourcing. Roles and responsibilities of various management levels were also not clear and were depicted differently depending on the governing document being referenced. It appeared that these governing documents were prepared and published, from the initial USD (P&R) and DSPO organizational structure in 2012 through the development of the USD (P&R) organizational chart in 2015, without being synchronized. This lack of synchronization negatively impacted *organizational structure, committee leadership, and committee charters* and their designated *responsibilities and interactions,* which resulted in significant inconsistencies and confusion. Table 2 illustrates the significant inconsistencies.

Table 2. Comparison of DoD Directive, SPGOSC and SPARRC Charters, and Current Practice

	DoDD 2013	SPGOSC Charter 2013	SPARRC Charter 2013	In Practice 2015*
Organizational structure; reporting chain	Through DASD(R) to ASD (R&FM) to (P&R)	NA	NA	Through DHRA to USD (P&R)
Co-Chairs SPGOSC	DASD(R)	Military Deputy to USD (P&R)	NA	Unknown: last meeting DHRA
Mission SPGOSC	Advisory to USD (P&R)	Advisory to USD (P&R)	NA	Advisory to USD (P&R)
	Facilitate review of SP policy and programs	Facilitate review of SP policy and programs	NA	Facilitate review of SP policy and programs
	Address present and emerging SP needs	Address present and emerging SP needs	NA	Address present and emerging SP needs
Decision making by SPGOSC	Facilitate review of assessment, integration, standardization, implementation, and resourcing of SP policy and programs: *does not state SPGOSC has decision making authority*	Facilitate review of assessment, integration, standardization, implementation, and resourcing of SP policy and programs: *does not state SPGOSC has decision making authority*	NA	Evidence supports role as advisor, not decision maker
Action execution by SPGOSC	Does not state SPGOSC executes actions	Does not state SPGOSC executes actions	NA	Evidence supports limited actions taken by SPGOSC; limited actions returned to SPARRC for implementation
Mission SPARRC	Collaborative forum between DSPO and the Services THROUGH the SPGOSC	NA	Collaborative forum BETWEEN DSPO, Services, SPGOSC, and other stakeholders	Collaborative forum BETWEEN DSPO, Services, SPGOSC, and other stakeholders
Decision making by SPARRC	Advises SPGOSC on SP issues, identifies policy and programs changes, and submits recommendations to the SPGOSC for approval	NA	REPORTS and advises, identifies policy, and programs changes, submits recommendations for approval, and facilitates and implements action items approved by the SPGOSC	Evidence supports information and recommendations, being filtered by Director, DSPO prior to SPGOSC
Action execution by SPARRC	*Does not state executes actions*	NA	Facilitates and implements action items approved by the SPGOSC	Evidence supports limited actions returned to SPARRC for implementation

Source: DoD OIG

LEGEND *(inconsistencies noted with shaded text)*

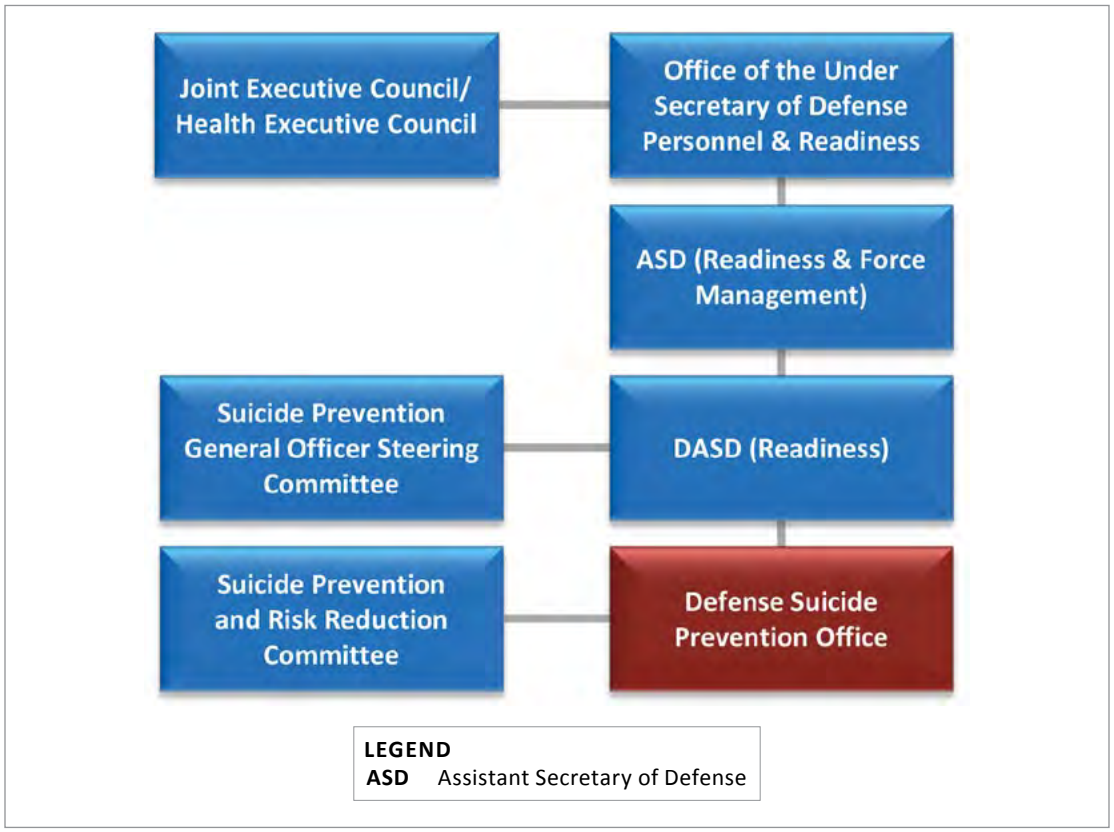
ASD (R&FM) Assistant Secretary of Defense for Readiness and Force Management
DODD Department of Defense Directive
NA not applicable
SP Suicide Prevention

*As evidenced during our fieldwork

USD (P&R) Organizational Structure

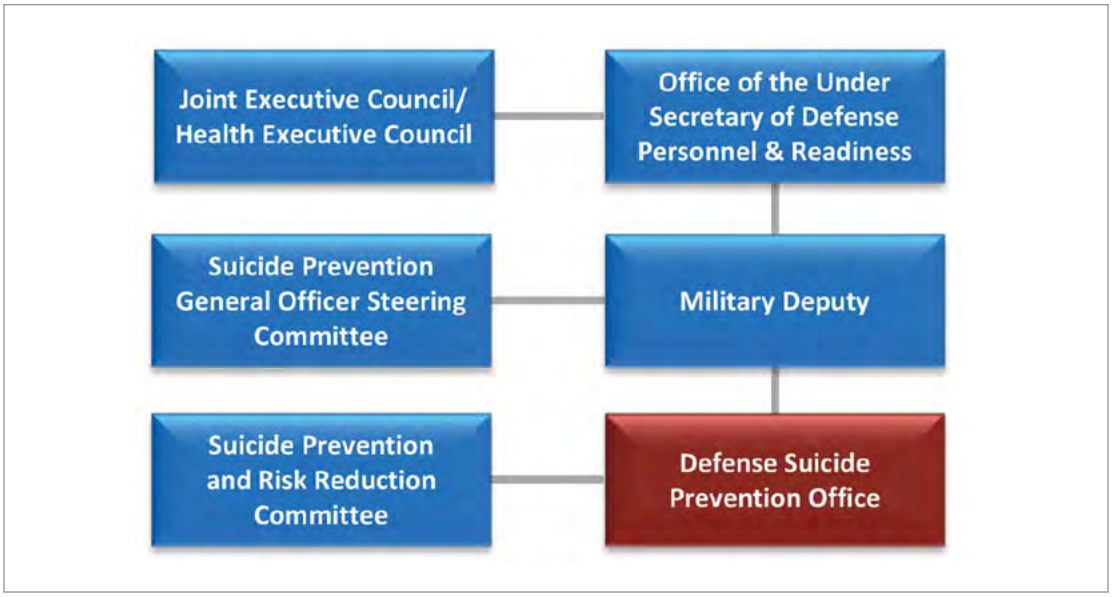
Prior to the 2013 issuance of the Directive, DSPO received direction and control from the Deputy Assistant Secretary of Defense for Readiness (DASD [R]) who was responsible for strategic oversight of the Defense Suicide Prevention Program. DASD (R) received authority from the Assistant Secretary of Defense for Readiness and Force Management to provide the oversight. Figure 1 depicts the organizational structure of USD (P&R) and DSPO in 2012. Figure 2 depicts the USD (P&R) and DSPO Organizational Structure in 2013.

Figure 1. USD (P&R) and DSPO Organizational Structure, 2012



Source: Structure Taken from Defense Suicide Prevention Office, Annual Report, 2012

Figure 2. USD (P&R) and DSPO Organizational Structure, 2013



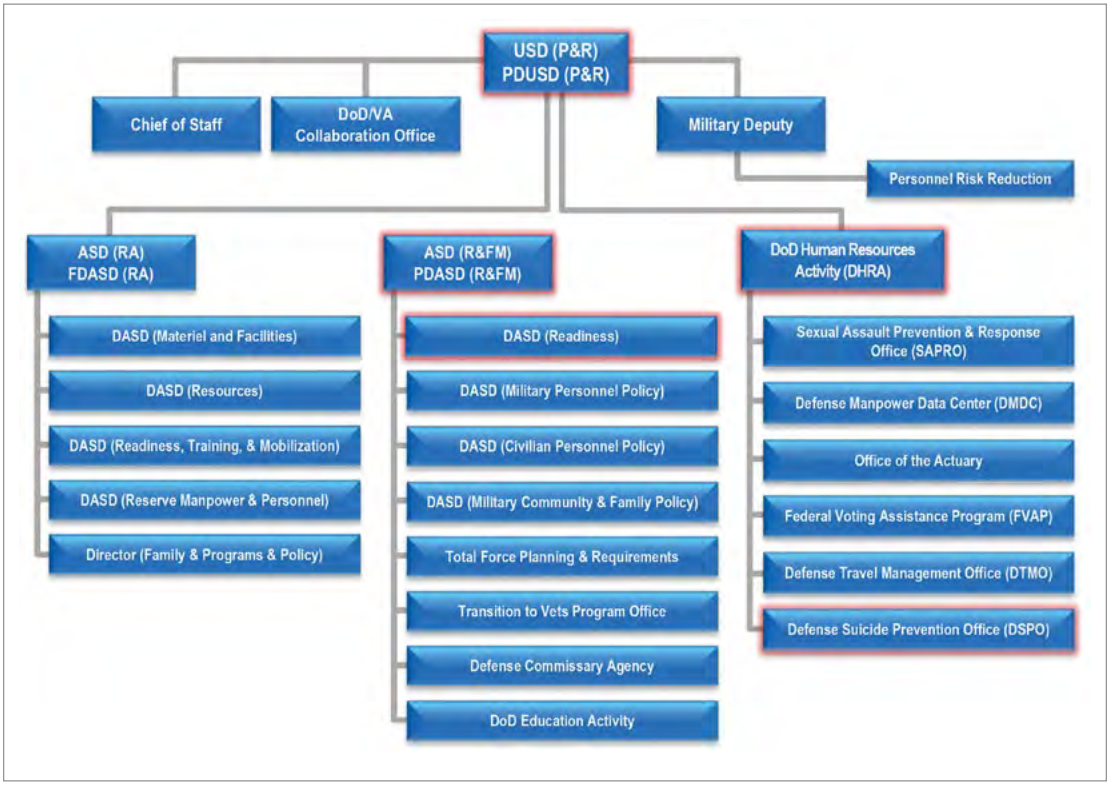
Source: Structure Taken from Defense Suicide Prevention Office, Annual Report, 2013

The Directive became the governing document that provided guidance for structure, mission, roles, and responsibilities. It established DSPO's alignment within the USD (P&R) hierarchy specific to the Defense Suicide Prevention Program. The Directive stated DSPO received policy oversight from DASD (R), through the Assistant Secretary of Defense for Readiness and Force Management, with direction and control coming from the Department of Defense Human Resources Activity (DHRA), to USD (P&R).

As DSPO continued to evolve as an organization, changes were made to the organizational structure. The difference between the organizational relationships depicted in Figure 1 and Figure 2 is that the DASD (R) and the Assistant Secretary of Defense for Readiness and Force Management were replaced by the Military Deputy.

As of 2015, DSPO reports directly to DHRA, which reports to the USD (P&R). However, the responsibility for providing strategic oversight was not transferred from DASD (R) to DHRA and it remains unclear where the responsibility resides. Figure 3 depicts the 2015 USD (P&R) organization and leadership structure.

Figure 3. OUSD (P&R) Organization and Leadership, 2015



Source: DoD OIG

During interviews with key stakeholders and analysis of documents, it became evident that over the previous years, the provision of organizational leadership and strategic oversight of the DoD Suicide Prevention Program was inconsistent. Since its issuance, the Directive has not been modified to reflect the evolving organizational structure. An organizational structure in the Directive that supports the mission with a streamlined hierarchy and integrated leadership would foster more effective strategic oversight by DoD.

Committee Leadership

The Directive and the SPGOSC charter were not synchronized in designating a committee chair. The Directive stated that the SPGOSC was co-chaired by the DASD (R); however, the SPGOSC charter stated it was co-chaired by the Military Deputy. The DASD (R) last co-chaired the SPGOSC in 2013, at which time the Military Deputy USD (P&R) assumed the co-chair role. The Military Deputy co-chaired the committee through May 2014. The last SPGOSC meeting was co-chaired by the Director, DHRA in November 2014. Changing committee co-chairs, which took place nearly every year, could have negatively impacted committee continuity, program focus, and strategic direction.

Committee Charters, Designated Responsibilities and Interactions

The responsibilities assigned to the SPARRC and the SPGOSC were not clearly defined in the language of the Directive and the two committee charters, as depicted in Table 2. Based on our interviews with SPARRC committee members, they voiced confusion regarding information flow, decision making, and action execution, which led to an inability to address or resolve suicide prevention action items.

According to the Directive and SPARRC charter, the SPARRC's responsibility was to advise and submit recommendations to the SPGOSC on suicide prevention issues, to improve suicide-related programs, and to facilitate collaboration between federal partners. The SPARRC charter further delineated that the SPGOSC reviewed SPARRC members' recommendations and, if approved, conveyed decisions back to the SPARRC for facilitation and implementation. In practice, the DSPO Director submitted recommendations to the SPGOSC without concurrence from SPARRC members.

Responsibility for the approval of recommendations and tasking authority to execute actions were not defined in the Directive or the SPGOSC charter, which further compounded the confusion of committee members. Both the Directive and SPGOSC charter specified that the SPGOSC only served as an advisory body to USD (P&R), and did not specify its relationship with the SPARRC for decision making and action execution.

Conclusion

The inconsistencies and gaps we noted between the Directive and the SPGOSC and SPARRC charters pertaining to governance structure, relationships, information flow, and decision making processes fostered misinterpretation and confusion between the two committees.

Based on our analysis of documents, we concluded that the lines of organizational leadership were inconsistent with the Directive's guidance for authority, direction, and control.

To provide clear direction, the organizational structure and governing documents should be synchronized. The lines of authority and responsibility for the Defense Suicide Prevention Program must be clearly defined at all levels to ensure effective strategic oversight and implementation of the program.

Recommendations, Management Comments, and Our Responses

Recommendation 1

We recommend the Under Secretary of Defense for Personnel and Readiness:

a. Revise the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," to clearly define and integrate the leadership roles and responsibilities of the Assistant Secretary of Defense for Readiness and Force Management, Deputy Assistant Secretary of Defense for Readiness, Defense Human Resources Agency, and Defense Suicide Prevention Office regarding program strategic oversight, decision making, and action execution.

Under Secretary of Defense for Personnel and Readiness Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated that the Directive is being revised to ensure that it correctly aligns the roles and responsibilities in the Department's suicide prevention efforts.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation. Although the Acting Under Secretary of Defense for Personnel and Readiness agreed with the recommendation, no timeline for revision of the Directive was provided. The Office of the Inspector General will follow-up with the Acting Under Secretary of Defense for Personnel and Readiness on the revised DoD Directive guidance.

b. Subsequently revise and synchronize the Suicide Prevention and Risk Reduction Committee and Suicide Prevention General Officer Steering Committee charters with the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," to ensure program governance structure and responsibilities are clearly defined and aligned.

Under Secretary of Defense for Personnel and Readiness Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated the charters governing the Suicide Prevention and Risk Reduction Committee and Suicide Prevention General Officer Steering Committee are being revised to define and align responsibilities, and to ensure a collaborative decision making approach toward suicide prevention.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation. Although agreeing with the recommendation, the Acting Under Secretary of Defense for Personnel and Readiness did not provide any further information on the revised governing committee charters or an anticipated timeline. During the revision of the governing charters, emphasis must be placed on clarifying the responsibilities between the committees with regard to decision making, and approval and tasking authorities in order to avoid confusion by committee members. The Office of the Inspector General will follow-up with the Acting Under Secretary of Defense for Personnel and Readiness.

Observation 2

Lack of Clear Planning, Direction, and Guidance

The DSPO lacked clear processes for planning, directing, guiding, and resourcing to effectively develop and integrate the Suicide Prevention Program within the DoD.

This occurred because DSPO did not fully develop a suicide prevention strategic plan, did not publish a DoD Instruction, and had not aligned staff against mission priorities.

As a result, there was no unified and coordinated effort to address suicide prevention across the DoD, and the Services continued to create their own Service-unique suicide prevention initiatives.

Discussion

In August 2010, the Task Force issued its report of findings that contained 76 recommendations for suicide prevention policy and programs. In September 2011, DoD provided a response to Congress detailing a plan to address the 36 recommendations that required DoD action. DoD stated the Department would ensure the best possible solutions were identified and implemented within 24 months.[5] As of December 2014, DSPO reported 21 of the 36 recommendations were not completed. To comply with Task Force recommendation number 1 "to build, staff, and resource a central OSD Suicide Prevention Office that can effectively develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities," the USD (P&R) established DSPO in 2011.

Given DSPO's magnitude of responsibility and in order to address the Task Force recommendations, DSPO developed a strategic plan. The DoD DSPO Strategic Plan 2012–2016 was a replication of DoD's response to Congress with the 36 recommendations as the basis. These recommendations became the objectives, and the associated tasks from the recommendations became the actions in the DSPO strategic plan. However, the plan did not include timelines to accomplish the objectives despite DoD's assurance to the Congress that the best possible solutions would be identified and implemented within 24 months. There was no evidence in the plan of a direction for the future.

[5] Response to Congress on Section 733 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Phase 2 Response to Department of Defense Task Force Report on Prevention of Suicide by Members of the Armed Forces, August 2010, "The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives," September 2011.

Resources necessary to develop and execute the strategic plan were not fully established. Throughout DSPO's existence, personnel and funding continued to fluctuate and evolve. Initially, DSPO was assigned five personnel who were detailed from within USD (P&R); however, DSPO was authorized 10 personnel. The organization did not reach its full complement of assigned personnel until FY 2013, and continues to require contracted personnel to support its mission. DSPO received its baseline funding plus additional funding above the President's budget request (sometimes referred to as "Congressional adds"). The budget funded office operations, while the "Congressional adds" were used for existing contracts and other suicide prevention initiatives that were approved by the Director, DSPO or congressionally directed. Several stakeholders commented that the funding amounts fluctuated and were unpredictable. During our interviews, we were told that DSPO did not use a deliberate process, sometimes referred to as a Program Budget Advisory Committee, to manage and allocate resources.

Lack of Direction: Deficiencies Identified in the Strategic Plan

A strategic plan provides a road map, direction, and focus for an organization's future. It forces the alignment of activities with the unified, future direction of the organization and sets priorities for crucial strategic tasks. The plan establishes measures to evaluate progress and allocates resources to the programs with the highest return/priority.[6] DSPO was unable to fully realize the benefits of strategic planning, as its 2012–2016 plan was incomplete. In DSPO's plan, situational analysis was limited to a historical perspective and did not fully address strengths, weaknesses, opportunities, and threats as part of the foundation for its strategic planning. The mission, vision, goals, and objectives were developed; however, the actions associated with those objectives did not reflect measures for success, timelines for completion, or resources required to achieve the objective. There was no evidence that DSPO's strategic plan was a working document that was monitored and updated annually to ensure the organization's success.[7]

Lack of Guidance: DoD Instruction

The Directive established policy and assigned responsibilities for implementing the Defense Suicide Prevention Program in accordance with the recommendations of the Task Force report. However, USD (P&R) did not follow through with the publication of a DoD Instruction to implement the plan or action for carrying out the directive. The DoD Instruction and the comprehensive training plan framework for suicide prevention were drafted in 2013; however, as of August 2015, neither has been published. In the absence of the Instruction and the training framework, the Military Services developed Service-unique programs and policies to address suicide prevention.

[6] Zuckerman, Alan M., "Healthcare Strategic Planning," Third Edition, 2012. Health Administration Press, Foundation of the American College of Healthcare Executives, Chicago, Illinois, page 11.

[7] Zuckerman, Alan M., page 119.

As a result of not having a comprehensive, fully developed strategic plan, Service leaders did not approach suicide prevention consistently and could not define a unified direction for the future. The lack of direction further impeded DSPO in accomplishing its mission and corresponding objectives.

Efficiency and Effectiveness of Committees

SPGOSC and SPARRC

Our analysis of the SPGOSC 2013 through 2014 meeting minutes and the SPARRC 2014 through 2015 minutes revealed that each group met consistently, but it was unclear how efficient and effective the meetings were in advancing suicide prevention actions. The "due outs" from the committees' minutes were not monitored for action or completion. Instead, topics were often tabled and either not revisited until months later or not at all.

There were 76 action items noted in the analysis of the SPGOSC minutes:

- 26 documents in various stages of development, production, or review,
- 15 briefings in various stages of development, production, or review,
- 15 actions requiring internal or external coordination,
- 13 actions requiring email communications, and
- 7 actions with no product/output.

Of the 76 action items, 28 were resolved for a 37% completion rate.
Of those 28 items:

- one took less than 6 months,
- one took less than 12 months,
- 22 took more than 12 months,
- one was unable to be tracked, and
- three did not require tracking to resolution.

There were 105 action items noted in the analysis of the SPARRC minutes:

- 20 documents in various stages of development, production, or review,
- 16 briefings in various stages of development, production, or review,
- 18 actions requiring internal or external coordination,
- 44 actions requiring email communications, and
- 7 actions requiring other than email communication.

Of the 105 items, five were resolved for a 5% completion rate. Of those five items:

- one item took less than 12 months,
- three items took more than 12 months, and
- one was unable to be tracked to resolution.

Priority Groups

DSPO's strategic plan established nine priority groups based on the 36 Task Force recommendations. The priority groups met periodically to address assigned recommendations.

One priority group, Program Analysis and Evaluation, was established to identify performance metrics. DSPO stated its willingness to identify qualitative and quantitative measurements to accurately evaluate the success of DSPO's work; however, the group has not agreed on any metrics to measure performance. In the absence of performance measurement, DSPO was not able to monitor progress and make timely adjustments to its strategic plan.

Conclusion

In 2011, DoD stated the Department would ensure the best possible solutions to the Task Force recommendations were identified and implemented within 24 months. DSPO established priority groups to implement the 36 Task Force recommendations that were the foundation for DSPO's strategic plan. The plan was incomplete as it lacked timelines, performance measures, and resourcing. Additionally, it was not monitored and updated, which made it unclear how efficient and effective the groups were in accomplishing the Task Force recommendations. Further, as action items from the chartered committees were identified, they were not tracked to completion. Those major action items requiring substantial staff effort to complete, such as metric and policy development, were not incorporated into the strategic plan for tracking and resolution. This resulted in actions not being completed. An effective review process could ensure priorities stayed on track, issues were identified and resolved, and resources were reallocated to accomplish goals and objectives.[8]

Additionally, in the absence of a published DoD Instruction, there was no standardized approach to suicide prevention. This lack of direction and guidance hampered DSPO's ability to unify and coordinate suicide prevention efforts across DoD. As a result, Service leaders continued to develop their own Service-unique programs and policies to address suicide prevention.

[8] Zuckerman, Alan M., page 175.

Recommendations, Management Comments, and Our Responses

Recommendation 2

We recommend that the Under Secretary of Defense for Personnel and Readiness:

a. Subsequently, upon revision of the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," (see Recommendation 1a.), develop and publish a comprehensive suicide prevention Department of Defense Instruction.

Under Secretary of Defense for Personnel and Readiness Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated the Department of Defense Instruction on suicide prevention is currently being drafted and will be expedited to the fullest extent practicable.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation, and no further comments are required.

b. Expedite publishing a Directive-Type Memorandum that provides interim Department of Defense suicide prevention guidance.

Under Secretary of Defense for Personnel and Readiness Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed in part and stated that they will assess the need for a Directive-Type Memorandum against defined Departmental policy.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation, and no further comments are required. We acknowledge the efforts being made to determine the best approach to provide timely suicide prevention guidance.

We recommend that the Defense Suicide Prevention Office:

c. Develop, publish, monitor, and communicate a comprehensive suicide prevention strategic plan with updated vision, goals, and objectives and include performance measures and timelines.

Defense Suicide Prevention Office Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated that the Defense Suicide Prevention Strategic Plan is currently being drafted and will include a comprehensive set of performance metrics.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation. Although the Acting Under Secretary of Defense for Personnel and Readiness agreed with the recommendation, no timeline for publication and implementation were provided. The incorporation of the strategic plan into day-to-day operations is imperative to ensure efficient and effective management of the Defense Suicide Prevention Program. The Office of the Inspector General will follow-up with the Defense Suicide Prevention Office on their published strategic plan.

d. Develop a plan that aligns budgetary and personnel resources to meet mission priorities.

Defense Suicide Prevention Office Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated that a plan is being developed to adequately resource personnel to accomplish mission priorities.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation, and no further comments are required.

Observation 3

Lack of a Plan to Implement Evidence-Based Suicide Prevention Strategies

DSPO did not consistently identify, share, or implement evidence-based[9] suicide prevention best practices across the DoD.

This occurred because the DSPO did not use the subject matter experts in the chartered committees (SPARRC and SPGOSC) to prioritize and advise on the implementation of evidence-based suicide prevention best practices across the DoD.

As a result the DoD did not standardize best practices across the department, and the Services did not take advantage of each others' knowledge and experiences.

Discussion

Task Force recommendation number 76 called for DoD to:

> create, a unified, strategic, and comprehensive DoD plan for research in military suicide prevention ensuring that the DoD's military suicide prevention research portfolio is thoughtfully planned to cover topics in prevention, intervention, and postvention.[10]

To address the Task Force recommendation, DoD solicited guidance from RAND National Defense Research Institute.

Research Strategy

In 2014, the resulting RAND report recommended "processes that DoD should adopt or enhance to ensure evidence supported suicide prevention strategies are integrated into current operations."[11] The report provided a consolidated list of past, ongoing, and current suicide prevention research studies. The studies were conducted by public and private agencies and were relevant to suicide prevention among military personnel. RAND also recommended that "leadership is needed to provide guidance for implementing a unified research strategy." Equally important, was the involvement of "peers in disseminating new research-based interventions."

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[9] Evidence-based practice is applying the best available research results (evidence) when making decisions about health care. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences. Systematic reviews (summaries of health care research results) provide information that aids in the process of evidence-based practice.

[10] "The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives," Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, August 2010.

[11] "Developing a Research Strategy for Suicide Prevention in the Department of Defense, Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward," RAND, 2014.

Despite the impetus from the Task Force and RAND recommendations, DSPO did not develop a comprehensive research strategy. Without an overarching implementation strategy, the Military Services continued to create their own individual suicide prevention initiatives based on the research they reviewed.

Implementation Strategy

DSPO partnered with internal and external research experts to develop an implementation strategy for translating suicide-related research into evidence-based practices, policies, and programs. DSPO did not capitalize on the suicide prevention subject matter experts within the SPARRC forum to analyze and prioritize evidence-based research findings and translate them into DoD clinical practice. SPARRC minutes did not consistently reflect whether committee members and suicide prevention subject matter experts had the opportunity to share, discuss, and advise on evidence-based best practices and research outcomes. During interviews, some SPARRC members indicated a need for more emphasis on research studies and best practices. Moreover, DSPO did not define and implement a comprehensive strategy to translate research findings into clinical practice. This lack of strategy hindered DoD's ability to standardize and benefit from implementing evidence-based suicide prevention best practices across the DoD.

Conclusion

The Task Force recommendation number 76 and the results of the 2014 RAND study provided guidance for DSPO to develop and publish comprehensive research and implementation plans. DSPO acknowledged in its annual report the importance of plans that focused on military suicide prevention.[12] However, DSPO did not effectively use suicide prevention and research subject matter experts to analyze, review, prioritize, and advise on the development of the plans. Consequently, DoD did not develop and publish either plan. This hindered DoD's ability to translate suicide-related research into standardized evidence-based best practices, policies, and programs across the DoD.

[12] DoD Defense Suicide Prevention Office Annual Report for Fiscal Year 2013, page27.

Recommendations, Management Comments, and Our Responses

Recommendation 3

We recommend that the Defense Suicide Prevention Office:

a. Develop a research strategy using subject matter experts to report and analyze evidence-based suicide prevention recommendations for applicability to Department of Defense.

Defense Suicide Prevention Office Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated that a defined strategy for research has been developed that includes a collaboration of research, clinical practice, and policy subject matter experts.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation. Although the Acting Under Secretary of Defense for Personnel and Readiness agreed with the recommendation, no defined strategy for research was provided. We request evidence of the strategy be provided.

b. Provide an implementation strategy to adapt Department of Defense applicable evidence-based suicide prevention research findings into standard practices across the Department.

Defense Suicide Prevention Office Comments

The Acting Under Secretary of Defense for Personnel and Readiness agreed and stated that this is a strategic priority and the office will leverage experts with the Defense Suicide Prevention Office Research Consortium, Suicide Prevention and Risk Reduction Committee, and the Research Summits to discuss and adopt applicable evidence-based suicide prevention best practices across the DoD.

Our Response

Comments from the Acting Under Secretary of Defense for Personnel and Readiness addressed the specifics of the recommendation, and no further comments are required. Although agreeing with the recommendation, the Acting Under Secretary of Defense for Personnel and Readiness did not provide any further information on an implementation strategy or an anticipated timeline. The Office of the Inspector General will follow-up on the Defense Suicide Prevention Office efforts to adopt applicable evidence-based best practices across the DoD.


INSPECTOR GENERAL
INTEGRITY
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Appendix A

Scope

We conducted this assessment from November 2014 through August 2015 in accordance with the "Quality Standards for Inspections and Evaluations," published by the Council of Inspectors General on Integrity and Efficiency in January 2012. We planned and performed this assessment to obtain sufficient and appropriate evidence to provide a reasonable basis for our observations, conclusions, and recommendations based on our objectives.[13] Site visits within the National Capital Area were conducted from November 25, 2014, to July 10, 2015. In addition, the team attended the VA/DoD Annual Suicide Prevention Conference, Dallas, Texas, from January 27–29, 2015.

We reviewed National Defense Authorization Acts, Congressional Responses, DoD Directives, DoD Instructions, USD (P&R) Memorandums, and reports/studies from outside agencies. We also reviewed all pertinent documents received from DSPO including annual reports, organizational charts, committee charters, priority group updates, memorandum of understanding, memorandum of agreement, and suicide prevention guidance.

The purpose of this project was to assess the processes DoD uses to understand and respond to suicides in the military.

The following areas were within the scope of this project:

- DoD-level processes used to establish suicide prevention and intervention policies and programs, including, but not limited to, resilience, mental health treatment, substance abuse, and postvention in the military.

The following areas were outside the scope of this project:

- Service-specific policy or processes, unless those policies or processes specifically influence DoD processes.

From November 2014 to July 2015, we conducted interviews with the following:

- Director, Defense Human Resources Activity.
- Military Deputy, Under Secretary of Defense for Personnel and Readiness.
- Director, Defense Suicide Prevention Office (current).
- Director, Defense Suicide Prevention Office (former).

[13] The objective was to assess DoD processes used in the development of suicide prevention policy and to determine what process changes were required to improve suicide prevention and intervention policies and programs including, but not limited to, resilience, mental health treatment, substance abuse, and postvention in the military.

- Defense Suicide Prevention Office staff.
- Service Suicide Prevention Program Managers.
- SPARRC representatives.
- SPGOSC co-chairs.

We observed the following meetings:

- SPARRC: January 27, 2015, held during the annual VA/DoD Suicide Prevention Conference in Dallas, Texas.
- SDR Board of Governors held January 20, 2015.
- Measures of Effectiveness Working Group held March 19, 2015.

Methodology

To determine responsible agents, policy completion times, and overall efficacy of SPARRC and SPGOSC activities, we analyzed SPARRC 2014 through 2015 minutes and the SPGOSC 2013 through 2014 minutes. In our analysis of the minutes, we extracted "due outs" and tracked the related actions taken. We made note of when "due outs" were discussed, when the item appeared again in the minutes, who was responsible for each action item, required actions (including email communication and policy publications), coordination between the SPARRC and SPGOSC, and the length of time that lapsed until the item was resolved. Our analysis focused on the decision making process, not on how decisions were implemented. Separately we also reviewed the 2014 SDR Committee minutes.

Limitations

We limited our review to DoD organizations associated with the DSPO mission, including DSPO staff, participants in the chartered SPGOSC and SPARRC, and other working groups and/or task force priority groups.

On February 9, 2015, USD (P&R) announced the selection of a new director for the Defense Suicide Prevention Office. This selection of a new director limited our ability to observe the monthly SPARRC and quarterly SPGOSC meetings during our fieldwork because these committees' meetings were postponed until the new director completed her own assessment of the office. On January 27, 2015, the team observed a SPARRC meeting being held in conjunction with the VA/DoD Suicide Prevention Annual Conference. This may not accurately represent a SPARRC meeting because of the time, location, and limited participation of the members.

Use of Computer-Processed Data

We did not use any computer processed data in this assessment.

Use of Technical Assistance

The Quantitative Methods Division (QMD) assisted us by creating visual representations of the meeting minutes data. QMD used visual analytics methodology to analyze and develop charts to visually reveal patterns and processes. We used a narrative format to describe the charts provided by QMD.

Appendix B

Prior Coverage

During the last 5 years, the Government Accountability Office (GAO), the Department of Defense, the Department of Defense Inspector General, and the Army Audit Agency, Naval Audit Services, and the Air Force Audit Agency issued reports relevant to suicide prevention and psychological health.

Unrestricted GAO reports can be accessed at http://www.gao.gov.

Unrestricted DoD IG reports can be accessed at http://www.dodig.mil/pubs/index.cfm.

Unrestricted Army reports can be accessed from .mil and gao.gov domains at https://www.aaa.army.mil/.

Naval Audit Service and Air Force Audit Agency reports are not available online.

GAO

GAO-12-154, Defense Health, "Coordinating Authority Needed for Psychological Health and Traumatic Brain Injury Activities," January 25, 2012

DoD

Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, "The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives," August 2010

DoD IG

Report No. DODIG-2015-016, "Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment," November 14, 2014

Army

Army Audit Report No. A-2012-0093-IEM, "Behavioral Health Programs, Fort Bliss and William Beaumont Army Medical Center," April 25, 2012

Army Audit Report No. A-2012-0001-IEM, "Audit of Behavioral Health Programs, U.S. Army Garrison, Fort Sam Houston," October 4, 2011

Army Audit Report No. A-2011-0220-IEM, "Behavioral Health Programs, Fort Carson and Evans Army Community Hospital," September 30, 2011

Navy

Naval Audit Report No. N2012-0017, "Suicide Crisis Links and/or Phone Numbers on Department of the Navy Web Sites," January 30, 2012

Naval Audit Report No. N2011-0061, "Post-Deployment Health Reassessment at the U.S. Navy: Fiscal Years 2008, 2009, and 2010 Data Analysis, and Future Monitoring Recommendations," September 23, 2011

Naval Audit Report No. N2011-0010, "Post-Deployment Health Reassessment at the Marine Corps: Fiscal Years 2008 and 2009 Data Analysis, and Future Monitoring Recommendations," December 17, 2010

Air Force

F2012-0057-FBN000, "Community Action Information Board and Integrated Delivery System," 341st Missile Wing, Malmstrom AFB, Montana, May 21, 2012

F2012-0046-FBS000, "Community Action Information Board and Integrated Delivery System," 943rd Rescue Group, Davis-Monthan AFB, Arizona, May 17, 2012

Appendix C

Phased Approach to Assessment of DoD Suicide Prevention

Suicide prevention is multifaceted and requires a broad approach, which includes training in the following topics:

- Resilience.
- Suicide prevention.
- Identifying and responding to high-risk behavior, such as substance abuse and mental health issues.
- Crisis response.
- Intervention.
- After-care and decreasing the stigma toward help-seeking behavior.

Due to the complexity of suicide prevention, conducting a single comprehensive assessment would be a very lengthy process and could delay potential improvements. In response to the increased focus on the issue, the DoD OIG suicide prevention assessment team developed a phased approach to assess the DoD's Suicide Prevention Program (see Figure 4).

Figure 4. Suicide Prevention Project's Phased Approach

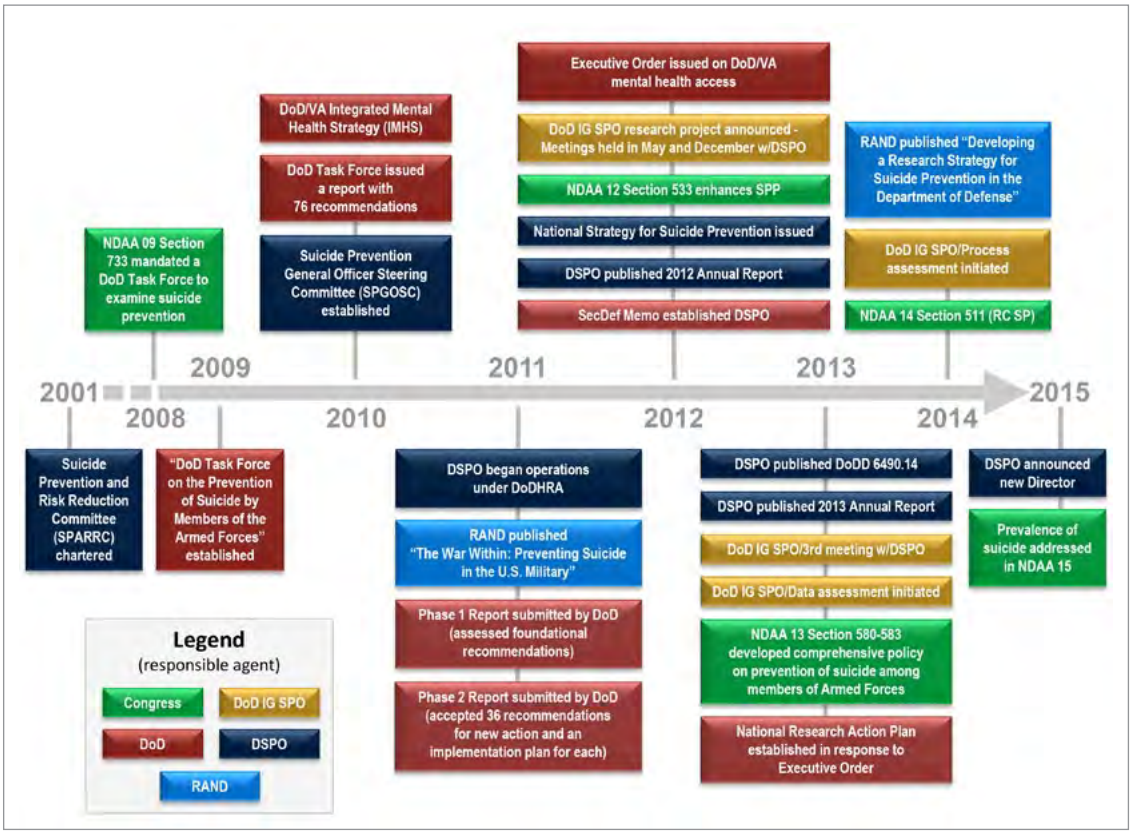
Source: DoD OIG

Appendix D

Defense Suicide Prevention Timeline

Figure 5 depicts a historical perspective of DoD efforts directed toward suicide prevention from 2001 to the present. This highlights the complexity of the issue and the continued congressional and DoD interest in it to have policy and programs in place aimed to reduce suicides within the DoD.

Figure 5. Defense Suicide Prevention Timeline by Calendar Year



Source: DoD OIG

Appendix E

Implementation of the 36 Recommendations that Require Action by the Department of Defense

Note: Excerpt taken from the Under Secretary of Defense for Personnel and Readiness (September 2011) Report to Congress on Section 733 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Phase 2 Response to Department of Defense Task Force Report on Prevention of Suicide by Members of the Armed Forces, August 2010, "The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives."

Targeted Recommendation 1

Build, staff, and resource a central OSD Suicide Prevention Office that can effectively develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities. This office should reside within the Office of the Under Secretary of Defense for Personnel and Readiness and be granted the coordinating authority that enables strategic suicide prevention oversight from OSD, through the Services, and down to the unit level.

Targeted Recommendation 2

Prioritize resources to adequately staff, fund, and organize the headquarters-level suicide prevention offices within each Service to successfully meet all current requirements.

Targeted Recommendation 3

Services should require full-time civilian suicide prevention coordinators at all installations identified by major commands. Major commands must facilitate the consistent implementation of Service suicide prevention strategy down to the small unit level and installations must ensure appropriate resourcing of this position in order to fully support both DoD suicide prevention policy and Service policy and programs.

Targeted Recommendation 6

Direct unit-level suicide prevention program officers to facilitate the implementation of Service policies.

Targeted Recommendation 10

Add validated behavioral risk questions to unit climate surveys to help commanders detect relative elevations in behavioral risk across their military units and respond with appropriate preventive measures. Mandate the use of unit climate and risk surveys annually and upon accepting and relinquishing command.

Targeted Recommendation 12

Disseminate and enforce "zero tolerance" policies that prohibit prejudice, discrimination, and public humiliation toward individuals who are responsibly addressing emotional, psychological, relational, spiritual, and behavioral issues; as well as toward those seeking help to increase their psychological fitness and operational readiness. Support these policies by holding leaders and supervisors accountable and by sustained communications campaigns.

Targeted Recommendation 13

Develop and implement sustainable training programs for PAOs [public affairs officers] serving Service leaders, senior leaders, and installation commanders in crafting health-promoting messages that support the goals and objectives of the Services' suicide prevention and health promotion programs. Avoid counterproductive or dangerous messages whenever making statements or discussing suicide-related information or statistics.

Targeted Recommendation 14

Instruct PAOs to disseminate nationally recognized recommendations for reporting on suicide as they interact with news media on the subject of suicide.

Targeted Recommendation 16

Develop an aggressive Stigma Reduction Campaign Plan communications effort and implement policies to root out stigma and discrimination. Follow scientifically based health communications principles in these campaigns.

Targeted Recommendation 18

Develop and implement campaigns to inculcate values and norms aligned with promoting the well-being, connectedness, and psychological and spiritual fitness of service members. Use well-planned, multi-year communications campaigns at the DoD and Service levels, employing the best of health communications science as part of that effort.

Targeted Recommendation 19

Target a specific component of the communications campaign to ensure that service members who hold security clearances and the mental health providers who see them are aware of policies that exclude reporting certain instances of mental health care on the SF-86.

Targeted Recommendation 23

Implement DoD and Service guidance for commanders and military recruit instructors that addresses the management of suicide-related behaviors during basic training.

Targeted Recommendation 24

Develop and implement a DoD-wide policy requiring immediate command notification and chain of care (or chain of custody) for individuals who become aware they are being investigated for a criminal or other serious offense, immediately after they confess to a crime, and/or soon after they are arrested and taken into custody.

Targeted Recommendation 25

Establish clear DoD, Joint, and Service guidance for removal and subsequent re-issue of military weapons and ammunition for service members recognized to be at risk for suicide. The guidance should emphasize a collaborative, team approach to the decision making process and specify documentation requirements.

Targeted Recommendation 27

Expand the practice of embedding behavioral health providers in operational units. Conduct studies to determine the range of effective staffing ratios for embedded providers.

Targeted Recommendation 32

Develop DoD and Service-level comprehensive suicide prevention training strategies. Develop and disseminate state-of-the-art training curricula addressing the specific knowledge, skills, and attitudes required of each sub-population in the military community. Incorporate industry-standard evaluation practices throughout the development and dissemination phases. Focus efforts on skills-based training.

Targeted Recommendation 33

Target and train families (including parents, siblings, significant others, and next of kin) as a suicide prevention training strategy, and consider it an important part of the chain of care for service members. Family members should be educated and trained to recognize the signs of stress and distress, to know whom to call for advice, and to understand how to respond in emergencies.

Targeted Recommendation 36

Implement policies that optimize access to care for all service members which are specifically designed for behavioral health care, and monitor access standards closely for compliance.

Targeted Recommendation 39

Implement coordination of care plans across longitudinal lines (e.g., permanent change of station, temporary change of station, deployment and redeployment transitions, temporary duty with other units, release from active duty, demobilization, confinement, hospitalization, and extended leave periods).

Targeted Recommendation 42

Promote and utilize coordinated community outreach and awareness activities provided by clinicians and other installation-based care providers to improve access to care and reduce stigma.

Targeted Recommendation 47

Develop, evaluate, and more widely disseminate peer-to-peer and other programs that intentionally promote not only connectedness but also risk identification and response among Reserve Component service members.

Targeted Recommendation 48

Promote easy access to evidence-based treatments and community support services for the post-deployment Reserve Component.

Targeted Recommendation 52

Take steps to make "mental fitness" commensurate with "physical fitness" within military culture as a core value of military life. Ensure every service member receives a mental fitness assessment and appropriate wellness education as part of his or her periodic heath assessment.

Targeted Recommendation 55

Suicide watch should be used only as a last resort and only until appropriate mental healthcare becomes available. Provide consistent guidance to units for these exceptional instances, as well as "just in time" training (e.g., online training). If units have a suicide prevention coordinator, the management of these rare instances could fall to that individual's responsibility. A suicide watch training program should be developed and similarly instituted.

Targeted Recommendation 60

Dedicate sufficient mental health resources to military health facilities to allow for timely mental health assessment and treatment.

Targeted Recommendation 61

Train all military healthcare providers (including behavioral health providers) and chaplains on evidence-informed suicide risk assessment, management, and treatment planning. Create and provide continuing education tailored to their specialty and area of expertise.

Targeted Recommendation 62

Incorporate postvention programs targeted at the decedent's military unit, family, and community after a tragedy or loss to reduce the risk of suicide. Postvention efforts must address service members affected by a significant loss, especially after a fallen comrade's death in combat or in garrison when the unit is impacted. Unit-level postvention efforts must focus on effective debriefing and prevention when they are impacted by a significant tragedy or loss.

Targeted Recommendation 63

Train first responders, chaplains, casualty notification officers, and family interviewers on how to best respond to suicide and suicide-related events when working with families or next of kin.

Targeted Recommendation 64

Provide families with comprehensive emotional support following the death of a loved one by suicide. All those affected, including significant others and battle buddies, should have access to resources that will help them cope with traumatic grief, such as the peer-based support organization Tragedy Assistance Program for Survivors (TAPS) and the Department of Veterans Affairs (VA) Vet Centers. These organizations offer free services to all who are grieving, with focused support for suicide loss.

Targeted Recommendation 67

Structure DoD to implement surveillance efforts in a standardized manner, with a core focus on informing and improving suicide prevention activities. The DoDSER must be matured, expanded, and refocused to fulfill this surveillance role.

Targeted Recommendation 68

Standardize Department of Defense Suicide Event Report (DoDSER) surveillance throughout the DoD, including specification of qualifications of surveyor and required training.

Targeted Recommendation 69

Facilitate consistent and fluid access to Defense Medical Surveillance System (DMSS) by DoDSER for appropriate surveillance purposes that also allows for automatic filling of select data fields as appropriate. Aggregation of surveillance data reported using the DoDSER is intended to inform suicide prevention efforts across DoD and the Services through centralized offices at both levels. Thus access to DMSS is essential.

Targeted Recommendation 70

Standardize the suicide investigation process across DoD with the sole focus being suicide prevention. The investigation should be nonattributional, be all-inclusive of the days and weeks preceding a suicide or suicide attempt, and be reported in a redacted form from the Services to OSD to maintain confidentiality.

Targeted Recommendation 74

Recommend legislation to create procedures that facilitate the timely transfer and sharing of civilian autopsy findings on service members (Active Duty, Reserve Component, National Guard) with the Armed Forces Medical Examiner's Office. Evaluate the appropriateness and necessity of access to other civilian findings to improve the tracking of members of the Armed Forces at-risk.

Targeted Recommendation 75

Every suicide prevention program initiated by DoD or the Services must contain a program evaluation component.

Targeted Recommendation 76

Create a unified, strategic, and comprehensive DoD plan for research in military suicide prevention: (1) ensuring that the DoD's military suicide prevention research portfolio is thoughtfully planned to cover topics in prevention, intervention, and postvention; and (2) assisting investigators by creating a DoD regulatory and human protections consultations board that is responsible primarily for moving suicide-related research forward in an expedited manner.

Management Comments

Under Secretary of Defense for Personnel and Readiness and Defense Suicide Prevention Office

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

SEP 22 2015

MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, SPECIAL PLANS AND OPERATIONS

This memorandum is my response to your request for comments on the Office of the Inspector General draft report, "Assessment of DoD Suicide Prevention Process," dated August 24, 2015 (Project No D2015-D00SPO-0052.000).

We have been reviewing our Suicide Prevention Program and have made important strides forward. During the period of the Department of Defense Inspector General assessment, we hired a new Senior Executive Service Director, finalized a Departmental Suicide Prevention Strategic Plan, and established a revised governance structure to ensure structure and responsibilities are clearly defined and aligned.

Attached are our comments to your findings and recommendations. I sincerely appreciate the opportunity to review and provide comments on this report. My point of contact for this matter is [redacted].

Brad Carson
Acting

Attachment:
As stated

Under Secretary of Defense for Personnel and Readiness and Defense Suicide Prevention Office (cont'd)

Department of Defense Comments on OIG Draft Report
"Assessment of DoD Suicide Prevention Process," dated August 24, 2015.
(Project No. D2015-D00SP0-0052.000)

Recommendation 1a: "Revise the Department of Defense Directive 6490.14, Defense Suicide Prevention Program," to clearly define and integrate the leadership roles and responsibilities of the Assistant Secretary of Defense for Readiness and Force Management, Deputy Assistant Secretary of Defense for Readiness, Defense Human Resources Activity, and the Defense Suicide Prevention Office regarding program strategic oversight, decision making, and action execution."

Response: Agree. While we agree that Department of Defense Directive 6490.14 needs revision, the Defense Suicide Prevention Office has not been aligned under the Assistant Secretary of Defense for Readiness and Force Management, nor the Deputy Assistant Secretary of Defense for Readiness since August 2014. The Director, Defense Suicide Prevention Office reports directly to the Director, Defense Human Resources Activity, thereby aligning all program strategic oversight, decision making, and action execution under one Personnel and Readiness component. We are currently embarking on a change to the Directive to ensure it correctly aligns the roles and responsibilities in the Department's suicide prevention efforts.

Recommendation 1b: "Subsequently revise and synchronize the Suicide Prevention and Risk Reduction Committee and Suicide Prevention General Officer Steering Committee charters with the Department of Defense Directive 6490.14, "Defense Suicide Prevention Programs," to ensure program governance structure and responsibilities are clearly defined and aligned."

Response: Agree. The Defense Suicide Prevention Office revised and is currently coordinating the charters governing the Suicide Prevention and Risk Reduction Committee (SPARRC) and Suicide Prevention General Officer Steering Committee (SPGOSC) to ensure program governance structure and responsibilities are defined and aligned to ensure a collaborative decision making approach towards suicide prevention.

The SPARRC's mission and role are to:

1) Serve as a collaborative forum of subject matter experts to facilitate the flow of information between the Defense Suicide Prevention Office, Military Services, and other stakeholders for the exchange of best practices and lessons learned.

2) Report to and advise the Director, Defense Suicide Prevention Office on suicide prevention issues; identify policy and program changes required to improve suicide-related programs; submit recommendations to the Director, Defense Suicide Prevention Office for approval; and facilitate and implement action items approved by the SPGOSC.

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3) Facilitate collaboration between federal partners such as the Department of Veterans Affairs (VA), and Department of Health and Human Services, including the Substance Abuse and Mental Health Administration, Centers for Disease Control and Prevention, and National Institute of Mental Health.

The mission and role of the SPGOSC are to:

1) Serve as an advisory body to the USD(P&R).

2) Facilitate the review, assessment, integration, standardization, implementation, and resourcing of suicide prevention policies and programs.

3) Address present, emerging and future suicide prevention needs, and evidence-based practices for military and civilian personnel that have DoD-wide applicability and provide recommendations to the USD(P&R) via the Defense Suicide Prevention Office.

Both charters have been revised to focus on these missions and roles and have been de-conflicted to ensure the SPGOSC provides the collaborative Departmental oversight of the Department's suicide prevention efforts. Both governance structures have established meeting minutes and follow-up of action items.

Recommendation 2a: "Subsequently upon revision of the Department of Defense Directive 6490.14, "Defense Suicide Prevention Program," (see Recommendation 1a.), develop and publish comprehensive suicide prevention Department of Defense Instruction."

Response: Agree. The Defense Suicide Prevention Office is currently working on a suicide prevention Department of Defense Instruction and will expedite the timelines in accordance with the WHS/Directives Division expedited timeline for Department of Defense Instructions to the fullest extent practicable.

Recommendation 2b: "Expedite publishing a Directive-Type Memorandum that provides interim Department of Defense Suicide prevention guidance."

Response: Agree in part. In accordance with Department of Defense Instruction 5025.01, "DoD Issuances Program," October 14, 2014, "DTMs will be issued only for time-sensitive actions and only when time constraints prevent publishing a new issuance or incorporating a change to an existing issuance. DTMs must not be used to permanently change or supplement existing issuances. They will be effective for no more than 12 months from the date signed, unless extended in accordance with this instruction. "Time sensitive" actions are those that are:

Directed by Executive order;

Directed by the Secretary or Deputy Secretary of Defense;

A matter of urgent national security;

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A matter of urgent DoD policy as determined by an OSD Component head;

Required by recent (less than 3 months) change in law, statute, or government-wide regulation; or

Necessary to prevent imminent danger to life and health."

The Defense Suicide Prevention Office will continue to assess the need for DTMs against this defined Departmental policy. We are currently working on a suicide prevention Department of Defense Instruction and will expedite the timelines as referenced in 2a.

Recommendation 2c: "Develop, publish, monitor, and communicate a comprehensive suicide prevention strategic plan with updated vision, goals, and objectives and include performance measures and timelines."

Response: Agree. The DoD adoption of the 2012 National Strategy for Suicide Prevention (NSSP) noted in the report has been carried to the next level with the development of the Defense Strategy for Suicide Prevention (DSSP). The DSSP is enhanced beyond the NSSP as it contains a section and appendix that deal directly with operationalizing the Defense Strategy in terms of Policy, Education/Training, Research, Protocols/Procedures, Data/Analytics and Communications/Media. To put strategy-to-directives back in proper order, publishing the DSSP will be followed by development of a DoD Suicide Prevention Strategic Plan (using the aforementioned operators) and, ultimately, by the development of a DoD Instruction - the Policy, Responsibilities and Procedures for implementing the DSSP and the Strategic Plan. The Defense Suicide Prevention Strategic Plan is currently being drafted and COAs for developing and implementing such a plan are being socialized with the Components. The plan will capture ongoing strategic activities by the Department and then present planned activities for each objective in the Near-Term (1-2 year), Mid-Term (2-3 year) and Long-Term (4-5 year) horizons. Additionally, periodic (Annual, Biennial, Quadrennial) activities will be presented within those horizons as needed. Each objective will have at least one strategic activity for completion in one of the horizons that addresses that objective - most will have more than one activity. Each strategic activity will also have input and output measures and will be designed for a particular outcome related to the objective. It is important to note that these Strategic Level Activities are not the same as tactical level activities necessary to implement the strategy at the Component level.

A new plan for performance metrics was developed and staffed with the Services. This new plan provides for a simple yet comprehensive set of metrics that can be expanded as the program matures.

Recommendation 2d: "Develop a plan that aligns budgetary and personnel resources to meet mission priorities."

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Response: Agree. The Defense Suicide Prevention Office, through DHRA, is currently developing a plan to ensure it adequately resources the necessary personnel to perform the mission based on the desired organizational competencies.

Recommendation 3a: "Develop a research strategy using subject matter experts to report and analyze evidence-based suicide prevention recommendations for applicability to Department of Defense."

Response: Agree. The Defense Suicide Prevention Office agrees with this recommendation and has a defined strategy for research that focuses on embedding a strong foundation of evidence into all DoD suicide prevention activities. This overall strategy has been developed with the collaboration of research, clinical practice, and policy subject matter experts.

Recommendation 3b: "Provide an implementation strategy to adapt Department of Defense applicable evidence-based suicide prevention research findings into standard practices across the Department."

Response: Agree. The Defense Suicide Prevention Office agrees with this recommendation and has made it a strategic priority to ensure that all future DoD suicide prevention activities are implemented with a strong foundation of evidence.

The Defense Suicide Prevention Office will leverage the RAND report. "Developing a Research Strategy for Suicide Prevention in the Department of Defense. Status of Current Research, Prioritizing Areas of Need, and Recommendations for Moving Forward." RAND 2014 (mentioned by the IG). This work will occur through the SPARRC where evidenced based programing will be discussed and disseminated.

Additionally, the Defense Suicide Prevention Office recognizes that there are evidence-based suicide prevention practices that have successfully been translated and implemented in the DoD; i.e., safety planning, suicide screening, firearm means restriction, Caring Contacts, ASSIST training, etc. There are other evidence-based practices that have been adopted by a specific Service but that have not yet been disseminated throughout DoD; i.e., life and coping skills training, and Collaborative Assessment and Management of Suicide Behavior. Still other evidence-based practices have been successfully implemented in the civilian sector, but have yet to be piloted within DoD. The Defense Suicide Prevention Office is leveraging experts with the Defense Suicide Prevention Office Research Consortium and SPARRC to further disseminate and support the adoption of these evidence-based practices across DoD. The Defense Suicide Prevention Office will also leverage the two Research Summits to present the subject matter experts who have led the research behind these practices and to discuss the potential for further implementation.

Acronyms and Abbreviations

DASD (R)	Deputy Assistant Secretary of Defense for Readiness
DSPO	Defense Suicide Prevention Office
DHRA	Defense Human Resources Activity
DoDSER	Department of Defense Suicide Event Report
OSD	Office of the Secretary of Defense
SDR	Suicide Data Repository
SPARRC	Suicide Prevention and Risk Reduction Committee
SPGOSC	Suicide Prevention General Officer Steering Committee
USD (P&R)	Under Secretary of Defense for Personnel and Readiness
VA	Department of Veterans Affairs

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